SERFF Tracking Number: AFDL-126463653 State: Arkansas
Filing Company: American Fidelity Assurance Company State Tracking Number: 45097

Company Tracking Number: AMD2109

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: AMD2109 Critical Illness Limited Benefit Rider
Project Name/Number: AMD2109 Cross DIvisional Rider/AMD2109

### Filing at a Glance

Company: American Fidelity Assurance Company

Product Name: AMD2109 Critical Illness SERFF Tr Num: AFDL-126463653 State: Arkansas

Limited Benefit Rider

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 45097

Closed

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: AMD2109 State Status: Approved-Closed

Long Term

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Lisa Blaich, Tina Crooks, Disposition Date: 03/08/2010

Joelle Harbour

Date Submitted: 03/03/2010 Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

#### General Information

Project Name: AMD2109 Cross DIvisional Rider

Status of Filing in Domicile: Authorized

Project Number: AMD2109

Date Approved in Domicile: 12/08/2009

Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small and Large

Overall Rate Impact: Group Market Type: Employer, Association,

Trust

Filing Status Changed: 03/08/2010 Explanation for Other Group Market Type:

State Status Changed: 03/08/2010

Deemer Date: Created By: Joelle Harbour

Submitted By: Joelle Harbour Corresponding Filing Tracking Number:

AMD2109

Filing Description:

Submitted for your review is amendment rider AMD2109, Critical Illness Limited Benefit Rider. This optional rider will be used with all approved group disability income policies. Domiciliary state approval was granted on December.

Amendment rider AMD2109 will provide a one time benefit if, following the waiting period, the insured is diagnosed with

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one of the critical illnesses defined in the rider. The benefit is paid directly to the insured.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the state of Arkansas and such forms contain no provisions previously disapproved by the Department. The Flesch score is 50.

Thank you for your assistance in this matter. If you have any questions, please contact me at 1-800-654-8489, extension 5597 or at Joelle.Harbour@af-group.com

### **Company and Contact**

#### **Filing Contact Information**

Joelle Harbour, Compliance Analyst I joelle.harbour@af-group.com

2000 N Classen Blvd 405-523-5997 [Phone]

Oklahoma City, OK 73106

**Filing Company Information** 

American Fidelity Assurance Company CoCode: 60410 State of Domicile: Oklahoma

2000 North Classen BlvdGroup Code:Company Type: LAHOklahoma City, OK 73106Group Name:State ID Number:

(405) 523-2000 ext. [Phone] FEIN Number: 73-0714500

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## **Filing Fees**

Fee Required? No Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

American Fidelity Assurance Company \$50.00 03/03/2010 34586526

Company Tracking Number: AMD2109

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: AMD2109 Critical Illness Limited Benefit Rider
Project Name/Number: AMD2109 Cross Divisional Rider/AMD2109

## **Correspondence Summary**

#### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	03/08/2010	03/08/2010

SERFF Tracking Number: AFDL-126463653 State: Arkansas
Filing Company: American Fidelity Assurance Company State Tracking Number: 45097

Company Tracking Number: AMD2109

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: AMD2109 Critical Illness Limited Benefit Rider
Project Name/Number: AMD2109 Cross DIvisional Rider/AMD2109

## **Disposition**

Disposition Date: 03/08/2010

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: AMD2109

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: AMD2109 Critical Illness Limited Benefit Rider
Project Name/Number: AMD2109 Cross Divisional Rider/AMD2109

Schedule Item Schedule Item Status Public Access

Supporting DocumentFlesch CertificationApproved-ClosedYesSupporting DocumentApplicationApproved-ClosedYesFormGroup Critical Illness Limited BenefitApproved-ClosedYes

Rider

Company Tracking Number: AMD2109

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: AMD2109 Critical Illness Limited Benefit Rider
Project Name/Number: AMD2109 Cross Divisional Rider/AMD2109

nt or Rider

#### Form Schedule

Lead Form Number: AMD2109

Schedule	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Item	Number			Data		
Status						
Approved-	AMD2109	Certificate Group Critical Illness	Initial		50.000	AMD2109.pdf
Closed		Amendmen Limited Benefit Rider				
03/08/2010	)	t, Insert				
		Page,				
		Endorseme				

2000 N. Classen Boulevard

Oklahoma City, OK 73106

Effective Date:	
(If different fr	om the Policy or Certificate)

#### CRITICAL ILLNESS LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

You or Your as used throughout shall mean the Insured or the Insured's. We, Us, Our shall mean the Company.

#### RIDER SCHEDULE

**MAXIMUM CRITICAL ILLNESS BENEFIT:** [\$10,000, \$15,000, \$20,000, \$25,000]

CRITICAL ILLNESS WAITING PERIOD: [30, 60, 90] days

CRITICAL ILLNESS: Heart Attack

Kidney Failure Major Organ Failure

Paralysis Stroke

**REDUCTION IN BENEFITS AT AGE 70:** 50% of the Maximum Critical Illness Benefit

#### **DEFINITIONS**

Critical Illness means any of the Critical Illnesses listed in the Rider Schedule and defined in this Rider.

**Critical Illness Waiting Period** means the number of days shown in the Rider Schedule following the Effective Date of this Rider. No benefits will be paid for a Critical Illness when the Date of Diagnosis occurs during the Critical Illness Waiting Period.

**Date of Diagnosis** means the first date a Physician establishes the diagnosis of a Critical Illness through the use of objective clinical evidence.

**Heart Attack** means an acute myocardial infarction resulting in the sudden death of the heart muscle resulting from a blockage of one or more coronary arteries. A Physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms. The diagnosis must be based on an event, which consists of all of the following:

- (a) the sudden onset of symptoms consistent with a Heart Attack; and
- (b) elevation of cardiac (heart) biomarkers consistent with a Heart Attack; and
- (c) Electrocardiagraphic changes consistent with a Heart Attack.

The definition of Heart Attack does not include acute or chronic congestive heart failure, atherosclerotic heart disease, angina, including unstable angina, coronary disease or any other dysfunction of the cardiovascular system.

**Kidney Failure (Renal Failure)** means the diagnosis by a Physician of the irreversible failure of both kidneys from any cause that necessitates treatment by renal dialysis or kidney transplantation.

AMD2109 Page 1 of 3

**Major Organ Failure** means diagnosis of organ failure of the liver, both lungs, pancreas, or heart resulting in You being placed on the UNOS (United Network for Organ Sharing) list for transplantation. If You are on the UNOS list for transplantation for more than one organ transplant only a single benefit will be paid.

**Paralysis** means that You have experienced the complete loss of use of two or more limbs for at least 180 consecutive days as a result of a neurological injury. Paralysis must be expected to be permanent and must be diagnosed by a Physician board certified in Neurology. Limb is defined as a complete arm or leg. Paralysis as a result of Stroke is excluded.

**Stroke** means a sudden neurological impairment of sensory and/or motor functions due to aneurysm rupture, acute cerebral occlusion, or acute cerebral hemorrhage from a cerebral artery, which results in permanent damage to the nervous system. Stroke must be diagnosed by a Physician based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater. Stroke does not mean head injury, subdural hematoma, transient ischemic attack, multi-infarct dementia, or chronic cerebrovascular insufficiency.

#### **BENEFITS**

We will pay You the Maximum Critical Illness Benefit shown on the Rider Schedule if You are diagnosed with one of the Critical Illnesses defined in this Rider and:

- (a) the Date of Diagnosis is after the [30, 60, 90] day Critical Illness Waiting Period;
- (b) the Date of Diagnosis occurs while this Rider is in force; and
- (c) the Critical Illness is not excluded by name or specific description in this Rider.

This benefit will be paid only once during Your lifetime regardless of the number of Critical Illnesses diagnosed. Proof of diagnosis must be submitted before benefits are paid.

At age 70 the Maximum Critical Illness Benefit will reduce by 50%.

If You are eligible to receive the Critical Illness Benefit, but die before the benefit amount is paid, the benefit will be paid to Your designated beneficiary or, if none, the benefit will be paid to Your estate.

#### **EXCLUSIONS**

In addition to the Exclusions listed in the Certificate to which this Rider is attached, no benefits will be paid for any loss caused by or resulting from:

- (a) a Critical Illness when the Date of Diagnosis occurs during the Waiting Period;
- (b) a Critical Illness diagnosed outside of the United States; or
- (c) a Sickness or Injury not specifically defined in this Rider.

#### PRE-EXISTING CONDITION EXCLUSION

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs before You have been continuously covered under this Rider for 12 consecutive months.

This exclusion will not apply to a Critical Illness caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs after You have been continuously covered under this Rider for 12 consecutive months.

AMD2109 Page 2 of 3

**Pre-Existing Condition** means a disease, Injury, Sickness, physical condition or mental illness for which You have experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advise from a Physician,

during the 12-month period immediately before the Effective Date of this Rider. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

#### **TERMINATION**

Your coverage under this Rider will end on the earliest of:

- (a) the date the Maximum Critical Illness Benefit is paid; or
- (b) the end of the last period for which premium payment has been made to Us; or
- (c) the date You notify Us in writing to terminate coverage; or
- (d) the date this Rider is discontinued; or
- (e) the date the Policy is discontinued.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.

Secretary

AMD2109 Page 3 of 3

Company Tracking Number: AMD2109

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: AMD2109 Critical Illness Limited Benefit Rider
Project Name/Number: AMD2109 Cross Divisional Rider/AMD2109

### **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Approved-Closed 03/08/2010

Comments:

Attachment:

AMD2109\_Certification\_AR.pdf

Item Status: Status

Date:

Satisfied - Item: Application Approved-Closed 03/08/2010

Comments:

A1264 group application was approved in Arkansas on October 30, 2009.

Attachment:

A1264.pdf



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

## CERTIFICATION ARKANSAS

Date

This is to certify that the attached group hospital indemnity product, Form Number: AMD2109, complies with the requirements of:

Arkansas Rule & Regulation 19

Arkansas Rule & Regulation 49

ACA 23-80-206

ACA 23-79-138

John Lanier
Name

Vice President
Title

03/01/2010

## GROUP APPLICATION

# AMERICAN FIDELITY ASSURANCE COMPANY 2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

1. PROPOSED INSURED Last Name INFORMATION:			First Name		Full N	Full Middle Name		Suffix		
Age D	Date of Bir Mo Day	th	S∈ M □	ex F 🔲	Soc Sec Number	er Request Mo Day	ed Eff Date Yr	Date of En		t
Residence A	ddress:	Number 8	& Street (I	Not a P.O.	( )			Home Phone #		
City			St	ate		Žip	Со	untry of Citize	nship	
Mailing Address (if different than Residence)  City  State  Zip								ip		
Employer Na	ame		Emplo	oyer/MCP #	Salary: \$Annual Monthly			Occupation		
Are you cur	rently at	ole to pe	rform the	e duties of	your occupation	n?		Yes	No 🗌	
Applicant's										
2. BENEFI	TS APP									
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	New/Chg	Distrib	oution ID	Covered	Plan Code	Amount	Employee	Employer	Mode	Total
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[STD]	Η Η									
[Other]	片 片									
[Other]	님 님									
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3. BENEFI First Name	CIARY:	Middle N	Name		Last Name		Relationship to	o Insured C	Country of	Citizenship
4. ELECTION	ON: Th	ereby e	nroll, add	l or chang	e, as checked	above, group i	insurance cov	erage(s) for	which I a	ım eligible. I
					ions, if any, fror	m my pay.				
5. ACKNOW	NLEDGI	MENT:	I underst	and and a	gree that:					
<ul> <li>5. ACKNOWLEDGMENT: I understand and agree that:</li> <li>The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.</li> <li>If applying for disability income coverage, OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE,</li> </ul>										
	_				JLD READ MY	-	E FOR MORE	DETAILED	INFORI	MATION
					REDUCE MY		ificato for a ==	oro dotollad	ovolo	ion of the
					ed; and I should	read my Cert	ilicate for a m	ore detalled	explanat	ion of the
Pre-Existing Condition exclusion, if any.  • BROCHURE(S) #  HAS/HAVE BEEN							BEEN			
					ED A COPY/C	OPIES; OR, I			AND TH	IE
OPPORT	UNITY	O PRIN	II THE E	ROCHU	RE(S).			ase initial):		
<b>6. FRAUD NOTICE:</b> Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)										
AGENT SIG	AGENT SIGNATURE (where required by law) Date									
Agent #				s	SIGNATURE (A	pplicant)				

GROUP APPLICATION

# AMERICAN FIDELITY ASSURANCE COMPANY 2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

				1

PROPOSED INSURED'S NAME:						
<ul><li>HEALTH HISTORY:</li><li>7. Within the past 5 years, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:</li></ul>						
Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).	Yes □ No □					
8. Within the past 12 months, have you:						
Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?	Yes  No					
9. Are you currently pregnant?	Yes 🗌 No 🗌					
10. I hereby certify that I have read the above statements and all of the medical conditions or they have I also understand that additional investigation could occur at time of claim and any misrepresent herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.	ation contained					
(Please in	itial):					